

Data Elements sorted by Category

2.00 Record Descriptors

CHART_FAC_CD	Chart Facility Code	Code to designate the facility where this chart is located. See standard code table.
CHART_NBR	Chart Number	A patient's health record number (HRN) at the specified facility.
CHART_STATUS_CD	Chart Status Code	Status of the specified chart at the local facility.
DATA_1ST_ENTRY_DC	Data Entry Creation Date (character format)	Date the encounter record was created. Expected format is CCYYMMDD.
DATE_LAST_MOD_TS	Date of Last Update	Date this record was last modified by the local registration/encounter system. Date format is CCYYMMDD.
ENCTR_DEL_FG	Encounter Delete Flag	Flag received from the local system that indicates that this encounter was deleted from the local system.
ENCTR_EXPORT_TS	Encounter Export Date	Date this "snapshot" of the local encounter record was exported.
EXPORT_BOX_ASUFAC	Static ASUFAC of Exporting Box	Code used to identify the actual machine from where the data originated.
EXPORT_LOG_NBR	Export Log Number	Control number assigned to the export at the local level, that allows us to track the data back to the facility.
FIRST_MOD_DC	First Modified Date i.e., Export Begin Date (character format)	Begin Date of the date range used by the site to export data to the warehouse. Expected format is CCYYMMDD.
LAST_MOD_DC	Last Modified Date i.e., Export End Date (character format)	End Date of the date range used by the site to export data to the warehouse. Expected format is CCYYMMDD.
REG_CREATE_DC	Registration Record Create Date (character format)	Date that the registration record was created on the local system. Expected format is CCYYMMDD.
REG_STATUS_CD	Registration Status Code	Status of a patient registration record and all of its components, i.e. demographics, charts, aliases, and insurance eligibilities. A record may become inactive due to the death of patient, registration consolidated with another for same patient, etc.
SRC_BOX_SITE	Name of Exporting Box's Site	Name of Exporting Box's Site.
SRC_SYS_CD	Source System Code	Source System Codes will be unique across all source systems that feed the DW. Therefore, a particular code will also implicitly identify the source system that generated a particular record.
UNIQ_ENCTR_CODE	Unique Encounter ID	Unique encounter (visit) record identifier generated by the source system. Preferred format is a 5-char unique site identifier (agreed upon by the site and IHS) concatenated with a 10-char encounter id number unique within the source system. Format is right-justified and zero-filled.
UNIQ_REG_CODE	Unique Registration ID	Unique registration record identifier generated by the source system. (It is unique by registration record, not necessarily by patient if a given patient has more than one registration record at the same facility or different facilities.) Preferred format is a 5-char unique site identifier (agreed upon by the site and IHS) concatenated with a 10-char registration id number unique within the source system. Format is right-justified and zero-filled.

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3.00 Patient Demographics

BENEF_CLASS_CD	Beneficiary Classification Code	Classification of the type of patient, indicating a category under which an individual can become eligible for IHS benefits. See standard code table.
BIRTH_DC	Date of Birth (character format)	Patient's Date of Birth. Expected format is CCYYMMDD.
BLOOD_QUANTUM_CD	Blood Quantum Code	Code to designate whether or not the patient is an American Indian/Alaska Native and, if so, to what degree. See standard code table.
CITY_NM	City	City or town portion of this patient's mailing address.
COMM_RES_CD	Community of Residence Code	Code for the State/County/Community of Residence of the patient. See standard code table.
COMM_RES_START_DC	Date Moved To Community (character format)	Date when the patient first moved to this community of residence. Expected format is CCYYMMDD.
CONSULT_QTY	Number of Consults	Number of physician consultations with the patient during an inpatient stay. Not applicable for outpatient encounters.
DEATH_DC	Date of Death (character format)	Patient's Date of Death. Expected format is CCYYMMDD.
DEATH_ICD9_DX_CD	Cause of Death	ICD-9 code for cause of death. Nationally recognized standard code set. Preferred format is to include the dot.
FATHER_FIRST_NM	Father's First Name	Father's First Name.
FATHER_LAST_NM	Father's Last Name	Father's Last Name.
FATHER_MID_NM	Father's Middle Name	Father's Middle Name.
FIRST_NM	First Name	First name of the patient; could also be an alias.
FULL_NM	Full Name	Patient's name prior to parsing into first, middle, last, etc. The format is specific to the local system.
GENDER_CD	Gender	Sex of Patient as provided by the patient's registration information.
LAST_NM	Last Name	Last name of the patient; could also be an alias.
LOCAL_VERIF_CD	Local SSN Verification Code	Field used by local facilities if they use the SSA information sent them to update their local databases. If they update their records to a "verified" code, they can use this field to note it.
MAIL_ADDR_1	Mailing Address Street 1	First line of the street address portion of this patient's mailing address, P.O. box, or rural route address of the patient.
MAIL_ADDR_2	Mailing Address Street 2	Second line of the street address portion of this patient's mailing address, P.O. box, or rural route address of the patient.
MID_NM	Middle Name	Middle name of the patient; could also be an alias.
MOM_MAIDEN_FIRST	Mother's First Name	Mother's First Name.
MOM_MAIDEN_LAST_NM	Mother's Maiden Last Name	Mother's Maiden Last Name.
MOM_MAIDEN_MID	Mother's Middle Name	Mother's Middle Name.
NM_SUFIX	Name Suffix	Name suffix, such as Sr., Jr., III, etc.
NM_TITLE	Title	Title of the patient, such as Mr., Ms., Mrs., Miss, etc.
STATE_ABBR_CD	State Code	United States Postal Service state code for this patient's mailing address.
SVC_ELIG_CD	Service Eligibility Code	Code that specifies the types of services for which this patient was eligible. See standard code table. Note: Native Americans cannot be coded as ineligible.

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TRIBE_CD	Tribe Code	Indian tribe code specifying patient's tribal membership. See standard code table.
VET_FG	Veteran Flag	Identifies a person who has previously served in the US Military. Veterans generally receive special veteran's assistance for medical bills. Note: This flag indicates if the patient is a veteran. It is NOT intended to identify all patients who are eligible for veteran's benefits. Values: Y=Veteran, blank=non-Veteran.
ZIP_CODE	Zip Code	Zip code (5-char) for this patient's mailing address.
ZIP_CODE_EXTN	Zip Code Extension	The additional 4-characters that follow the 5-character zip code, if available, for this patient's mailing address.

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4.00 3rd Party Eligibility

CVG_TP_CODE	Coverage Type Code	Type of third party coverage for which the patient is eligible. Value depends on the associated insurance category code. If insurance category code = MCR or RRE, valid values for this field = A (Medicare Part A), or B (Medicare Part B). Otherwise, any free text value is accepted.
ELIG_END_DC	Eligibility End Date (character format)	Date that eligibility for the specific type of coverage ends. For Medicaid and Medicare, the eligibility end date; for private insurance, the expiration date. Expected format is CCYYMMDD.
ELIG_START_DC	Eligibility Start Date (character format)	Date that eligibility for the specific type of coverage begins. For Medicaid and Medicare, the eligibility date; for private insurance, the effective date. Expected format is CCYYMMDD.
INSUR_CAT_CD	Insurance Category Code	Type of Eligibility
INSURER_EIN	Insurer EIN	Insurer's Employer Identification Number.
INSURER_NM	Insurer Name	Name of the insurance company.
NBR_PREFIX_SUFFIX	Policy Prefix/Suffix	Policy suffix for Medicare, or prefix for Railroad Retirement.
PLAN_NM	Plan Name	Plan Name for Medicaid Coverage. Applicable Only for Medicaid.
PLCY_NBR	Policy Number	Insurance policy number.
PLCYHLDR_FIRST_NM	Policy Holder's First Name	First name of the insurance policy holder.
PLCYHLDR_LAST_NM	Policy Holder's Last Name	Last name of the insurance policy holder.
PLCYHLDR_MID_NM	Policy Holder's Middle Name	Middle name of the insurance policy holder.
RELAT_TO_INSRD	Relationship to Insured	Patient's relationship to the insured - applicable only for Medicaid and Private insurance. (e.g. self, spouse, etc.)
STATE_CD	Eligibility State Code	Numeric IHS-specific code indicating state where a patient is eligible for Medicaid.

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5.00 Encounter Demographics

ADMISS_SVC_CD	Admission Service	Code set indicating type of clinical service to which the patient was admitted. See standard code table.
ADMISS_TP_CD	Admission Type	Code indicating by what process a patient was admitted. See standard code table.
CLINIC_CD	Clinic Code	Code indicating the type of clinic at which this encounter occurred. See standard code table.
DAY_OF_WEEK_CD	Day of Week	Day Of Week the encounter/admission occurred.
DISCH_DC	Discharge Date (character format)	Inpatient: date patient discharged. Outpatient: not applicable. Expected format is CCYYMMDD.
DISCH_SVC_CD	Discharge Service Code	Code set indicating type of clinical service from which the patient was discharged. See standard code table.
DISCH_TP_CD	Discharge Type Code	IHS standard codes to identify how a patient was discharged from an inpatient visit. Not applicable for outpatient.
ER_DISP_CD	Disposition On ER Visits	The patient disposition code, if this is an ER visit.
LENGTH_OF_STAY	Length of Stay	Number of days the patient was in the inpatient setting. Not applicable for outpatient.
LOE_FAC_CD	Location of Encounter	Facility code for the location where the visit took place. See standard code table.
SVC_ADMISS_DC	Service / Admission Date (character format)	Outpatient: date of service. Inpatient: admission date. Expected format is CCYYMMDD.
SVC_CAT_CD	Service Category Code	Category of the service that was provided to the patient during this encounter. See standard code table.
SVC_LEVEL_CD	Service Level Code	Code that specifies the Level of Service for this encounter. See standard code table.
SVC_TP_CD	Service Type Code	A code that specifies the service type for this encounter. See standard code table.
TIME_OF_DAY	Time of Day	Time of day the encounter/admission occurred.
TRANSFER_FAC_CD	Transfer Facility Code	Code that is used to specify the facility to which the patient was transferred. The facility code is from a standard code table.

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7.00 Provider

ATND_PHYS_AFFL_CD	Attending Physician Affiliation Code	Affiliation of the attending physician. See standard code table.
ATND_PHYS_DISC_CD	Attending Physician Discipline Code	Discipline of the attending physician. See standard code table.
MIDWIFERY_FG	Midwifery Flag	A flag to indicate if the provider is a midwife.
PHYS_LOCL_CODE	Attending Physician Local Code	The code used at the site to identify the attending physician. Usually, but not always the physician's initials.
PROV_AFFL_CD	Provider Affiliation Code	The affiliation of the provider. If multiple affiliations are sent, the first occurrence listed is considered to be the affiliation of the primary provider. See standard code table.
PROV_DISC_CD	Provider Discipline Code	The discipline of the provider. If multiple disciplines are sent, the first occurrence listed is considered to be the discipline of the primary provider. See standard code table.
PROV_LOCAL_TEXT	Provider Local Code	Code used at the site to identify the provider. Usually, but not always the provider's initials.
PROV_X12_CLASS_CD	Provider Class X12 Code	HIPAA "provider classification" code, a more specific service or occupation related to the Provider Type. For example, the Classification for Allopathic & Osteopathic Physicians is based upon the General Specialty Certificates as issued by the appropriate national boards.
PROV_X12_SPEC_CD	Provider Spec X12 Code	HIPAA "provider specialization" code, a more specialized area of the Classification in which a provider chooses to practice or make services available. For example, the Area of Specialization for provider type Allopathic & Osteopathic Physicians is based upon the Subspecialty Certificates as issued by the appropriate national boards.
PROV_X12_TP_CD	Provider Type X12 Code	HIPAA "provider type" code, a major grouping of service(s) or occupation(s) of health care providers. For example: Allopathic & Osteopathic Physicians, Dental Providers, Hospitals, etc. See standard code table.

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8.00 Patient History

HTN_EVER_DOC_FG	HTN Ever Documented Flag	Has this patient ever had Hypertension documented? (Y/N)
HTN_LAST_DOC_DC	HTN Last Documented (character format)	Date Hypertension (HTN) was last documented, if ever. Expected format is CCYYMMDD.
LMP_DC	Last Menstrual Period (character format)	Last known menstrual period on file. Expected format is CCYYMMDD.
LMP_NOTED_DC	LMP Noted (character format)	Date the last menstrual period on file was noted. Expected format is CCYYMMDD.

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9.00 Measurements

CLIN_MEAS_CD	Clinical Measure Code	Code describing the type of measurement that is being captured.
CM_RSLT_VALUE	Clinical Measure Result Value	This field will be used for Blood Pressure, Height, & Weight. BP to be reported in ###/### format, height to be output in inches in ##.# format, weight in pounds in ###.# format.

Data Elements sorted by Category

10.00 Exams

EXAM_IHS_CD	Exam IHS Code	Exam that was performed on the patient during this encounter. See standard code table.
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11.00 Procedures

EVAL_MGT_CPT_CD	Evaluation and Management CPT Code	CPT code from evaluation and management field of visit file. Nationally recognized standard code set.
HCPCS_QTY	HCPCS Quantity	Number of HCPCS codes.
ICD9_PROC_CD	ICD9 Procedure Code	ICD-9 procedure code for the surgical procedure. If multiple procedure codes are sent, the first one is considered to be the primary procedure. Nationally recognized standard code set. Preferred format is to include the dot.
INFECT_FG	Infection Flag	Was this procedure related to an infection. (Y/N)
PROC_DC	Procedure Date (character format)	Date the procedure took place. Expected format is CCYYMMDD.

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12.00 Labs

FEC_OCLT_BLOOD_FG	Fecal Occult Blood Lab Flag	Was a fecal occult blood test performed during this encounter? (Y/N)
GLUCOSE_VAL	Glucose Value	Result value for a glucose test obtained during this encounter.
HDL_CHOL_FG	HDL Cholesterol Test Flag	Was an HDL cholesterol test performed during this encounter? (Y/N)
HDL_CHOL_VAL	HDL Cholesterol Value	Result value for an HDL cholesterol test obtained during this encounter.
HGBA1C_VAL	HGBA1C Value	Result value for a HGBA1C test performed during this encounter.
LAB_TEST_NM	Lab Test Name	Lab test name as stored in the local system.
LAB_TEST_QTY	Number of Lab Tests Done	Total number of lab tests that were performed for this visit.
LDL_CHOL_FG	LDL Cholesterol Test Flag	Was an LDL cholesterol test performed during this encounter? (Y/N)
LDL_CHOL_VAL	LDL Cholesterol Value	Result value for an LDL cholesterol test obtained during this encounter.
LOINC_CD	LOINC Code	Logical Observation Identifiers Names and Codes (LOINC). Nationally recognized standard code set to identify the lab test.
MICROALBUM_FG	Microalbuminuria Flag	Was an Microalbuminuria test performed during this encounter (Y/N)?
MICROALBUM_VAL	Microalbuminuria Value	Result value of the Microalbuminuria test performed during this encounter.
PAP_FG	Pap Lab Test Flag	Was a Pap test performed during this encounter? (Y/N)
PSA_FG	PSA Lab Test Flag	Was a Prostate Specific Antigen test performed during this encounter? (Y/N)
RANGE_LOWER_LMT	Range Lower Limit	Lower limit for the normal reference range of the associated lab test.
RANGE_UPPER_LMT	Range Upper Limit	Upper limit for the normal reference range of the associated lab test.
TRIGLYC_FG	Tryglyceride Test Flag	Was a triglyceride test performed during this encounter? (Y/N)
TRIGLYC_VAL	Triglyceride Value	Result value for a triglyceride test obtained during this encounter
UNIT_OF_MEAS	Unit of Measure	Unit of measure for the lab result.
URIN_PROTN_FG	Urine Protein Test Flag	Was a urine protein test performed during this encounter? (Y/N)
URIN_PROTN_VAL	Urine Protein Value	Result value for a urine protein test obtained during this encounter.

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13.00 Diagnoses

DX_CAUSE_CD	Cause of Diagnosis	Code designating the cause of this specified diagnosis. See standard code table.
DX_SEQ_NBR	Diagnosis Sequence Number	Sequence number of the diagnosis for which the CPT procedure was performed, if applicable. It is used to link this PROCEDURE record with the appropriate DX record.
ICD9_DX_CD	Diagnosis Code	ICD-9 diagnosis code. When multiple ICD-9 codes are sent, the first one is considered to be the primary diagnosis. Nationally recognized standard code set. Preferred format is to include the dot.
ICD9_EXT_INJ_CD	Cause of Injury	ICD-9 E-prefix code for the cause of the injury. (Only used if diagnosis code is between 800 and 999.9, meaning injury.) Nationally recognized standard code set. Preferred format is to include the dot.
INJ_PLACE_CD	Place of Injury	Code for the place of injury. (Only used if ICD-9 diagnosis code is between 800 and 999.9, signifying an injury.) See standard code table.

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14.00 Health Factors

HLTH_FACTR_CAT	Health Factor Category	Health factor category. (e.g., Tobacco)
HLTH_FACTR_CAT_CODE	Health Factory Category Code	Health factor category code.
HLTH_FACTR_CD	Health Factor Code	Health Factor code.
HLTH_FACTR_NM	Health Factor Name	Name of Health Factor. (e.g., previous smoker)

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15.00 Immunizations

HL7_IMMUN_CD	HL7 Immunization Code	Proprietary subset of HL7 used by IHS beginning with version 7.0 of the RPMS Immunization Package. This was replaced in version 8.0 with the complete HL7 CVX code list.
HL7_IMMUN_CVX_CD	Immunization Formulation Code	HL7's CVX code for the vaccine formulation.
HL7_IMMUN_MVX_CD	Immunization Manufacturer Code	HL7's MVX code for the vaccine's manufacturer.
IHS_IMMUN_CD	IHS Immunization Code	Proprietary code for immunizations used by IHS prior to version 7.0 of the RPMS Immunization Package.
IMM_DOSE_NBR_CD	Immunization Dose Number Code	The dose in an immunization series that was provided on this encounter. (Some immunizations require multiple doses over a period of time. Not necessarily a number.)

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16.00 Skin Tests

SKIN_TEST_CD	Skin Test Code	Code for a skin test performed during this visit. See standard code table.
SKIN_TEST_READING	Skin Test Reading	Numeric measurement in mm of a skin test measured during this visit.
SKIN_TEST_RSLT_CD	Skin Test Result Code	Code for a skin test result, reading performed during this visit. See standard code table.

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17.00 Medications

ACE_INHIB_FILL_FG	Ace Inhibitor Fill Flag	Was an ACE INHIBITOR prescribed and/or filled during this encounter (Y/N)?
MED_NDC_CODE	Medication NDC Code	National Drug Code (NDC) for this medication as stored in the local system. Nationally recognized standard code set
MED_NM	Medication Name	Name of the medication as stored in the local system.
MED_QTY	Medication Quantity	Quantity of medicine dispensed (e.g., number of pills, milliliters of a liquid preparation, grams of a topical cream, etc.). Entry is a number, units (# of pills, mls, mgs, etc.) are implicit in the NDC code. (Formatted as a number up to 9999999.999.)
VA_DRUG_CLASS_CD	VA Drug Class Code	Code representing the VA Drug Class. This code is assigned by the local system. See standard code table.

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18.00 Patient Education

DM_NUTR_EDUC_FG	DM Nutrition Education Flag	Was Diabetes Mellitus education given to the patient? (Y/N)
EDUC_CD	Education Code	Code that specifies the topic of education provided during this encounter. See standard code table.
EDUC_MINS	Length of Education	Length, in minutes, of the patient education provided for this specified topic.
EDUC_UNDERSTAND_CD	Education Understanding	Education - patient's level of understanding

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19.00 Dental

ADA_CD	ADA Code	American Dental Association code that designates the type of dental service provided during this encounter. Nationally recognized standard code set.
ADA_FEE_AMT	ADA Code Fee	Fee for this ADA Code rounded to the nearest dollar.
ADA_UNITS	ADA Units	Number of the services identified by the ADA code that were delivered (e.g., if the ADA code is for tooth extraction and there are three ADA units, that means three teeth were extracted).
COMMRCL_INSUR_FG	Commercial Insurance Flag	Used by contract (FI) dental. Is patient covered by commercial insurance? (Y or blank)
DEN_COST_AMT	Dental Cost	Dental Total Cost rounded to the nearest dollar.
DEN_DELIVERY_CD	Dental Delivery Code	The dental delivery modes designate whether this was a contracted patient encounter or a direct encounter.
DEN_PAT_TP_CD	Dental Patient Type Code	Patient's Indian status, used exclusively for dental encounters.
OPSITE_CD	Dental Operative Site	Code used to identify the tooth, range of teeth, or other location for which the ADA procedure was performed.
OPSITE_SURF_NBR	Dental Tooth Surface	Code used to identify the surface of the tooth for which the ADA procedure was performed.
RPT_DENTIST_SSN	Dentist's SSN	SSN for the dental provider. (format 999999999, no dashes.)

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20.00 PHN

PHN_ACT_CD	PHN Activity Code	Activity Code used for reporting Public Health Nursing visits.
PHN_ACTIVITY_MINS	PHN Activity Minutes	Total number of minutes to complete the Public Health Nursing activity.
PHN_INTERV_LVL_CD	PHN Intervention Level	Code indicating the level of intervention used during a Public Health Nursing activity.
PHN_TRAVEL_MINS	PHN Travel Minutes	Travel Time utilized for Public Health Nursing activity, recorded in minutes.

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21.00 CHS

AUTH_FAC_CD	Authorizing Facility	Facility that authorized the vendor to provide services to the patient. See standard code table.
AUTH_NBR	Authorization Number	For CHS visits, this is the tracking number assigned that authorizes the patient to see a contracted provider and obtain services external to available direct services.
CHS_COST_AMT	CHS Cost	For CHS (contracted health service) visits, total amount paid to the outside provider. Preferred format is 999999.99.
ENCTR_QTY	Encounter Quantity	What CHS considers workload units. This could be number of orders filled, number of devices, number of eyeglasses, number of prescriptions, etc., depending upon the Object Class Code.
PO_NBR	Purchase Order Number	Number assigned to the specific purchase order that authorizes contract services.

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100.00 Internal Record Designators

ENCTR_SKIPPED_QTY	PCC Visits Skipped (RPMS systems only)	Total number of PCC visits skipped (not exported).
FIELD_CHANGE_CODE	Any Field in this Subset Modified Since Last Exported?	Field used by the source system to indicate to the NDW how to process this subset of records. (A = Add a brand new registration; Y = Yes, subsection is different from the last export; N = No changes since the last export)
PCC_ENCTR_QTY	Number of PCC Visits	The total number of pcc visits that are contained in this export.
SEQ_NBR	Sequence Number	For the first occurrence, the sequence number is 1; for the second occurrence, the sequence number is 2, and so on.
SKIP_DEMO_PAT_QTY	Skipped Demo Patients (RPMS systems only)	Number of PCC visits not exported because the patient's name was 'DEMO, PATIENT'.
SKIP_ERROR_QTY	PCC Visit Errors (RPMS systems only)	Number of PCC visits skipped (not exported) due to error.
SRC_FL_EXPORT_DC	Source File Export Date (character format)	Date the export was run at the facility. Expected format is CCYYMMDD.
SRC_FL_REC_QTY	Source File Record Quantity	Total number of records contained in the source file, i.e., the file the IE receives from the facility. This should be the number of HL7 messages.

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100.20 SSA verification

SSN_PSEUDO	Social Security Number Pseudo-code	Composite field consisting of the social security number (or pseudo-ssn) and a flag indicating if it is an actual ssn or a pseudo-ssn assigned by the facility.
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